Texas Department of Aging and Disability Services

Form 2260
October 2012

Permanency Planning Instrument for Children Under 18 Years of Age (Family Directed Plan)

☐ **Initial** ☐ **Review**

Child's Name	LA Comp. Code/LA Case No	PP Meeting Date	Admission Date

Social Security No.	Medicaid No.	Date of Birth	Age

Facility Name	Contact Name	Area Code and Telephone No.

Parent/Guardian Name	Address (Street, City, State, ZIP Code)	Area Code and Telephone No.

The summary was compiled by (all should apply):

☐ Discussions with family/LAR ☐ Reviewing facility records
☐ Discussions with child ☐ Observing the child
☐ Discussions with facility staff ☐ Other (identify):

Completed by (enter name, affiliation and email address):	Area Code and Telephone No.

Section 1. Background Information

Part 1. Description of the Child – Who is this child?

A. Describe the child, the child's personality characteristics, attributes, likes, dislikes, behavior and reaction to others – in non-technical terms.

B. Description of the child's skills and abilities.

Level of intellectual disability ☐ N/A ☐ mild ☐ moderate ☐ severe ☐ profound ☐ unknown

Identify any sensory impairments ☐ vision ☐ hearing ☐ touch ☐ taste ☐ smell

Identify the child's developmental disability: _____

What does the child need help to do (e.g., eating, dressing, grooming, toileting)? Be specific.

Eating: _____

Dressing/Grooming: _____

Toileting: _____

C. Medical

Indicate medical conditions managed by professional health care intervention and specify the intervention type and frequency. (Attach additional pages, if necessary.)

Description of Condition: Physical Health	**Managed by Medication?**		**Managed by Health Care Intervention?**		**Describe the Intervention Type and Frequency**
	Yes	**No**	**Yes**	**No**	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	

Description of Condition: Mental Health	**Managed by Medication?**		**Managed by Health Care Intervention?**		**Describe the Intervention Type and Frequency**
	Yes	**No**	**Yes**	**No**	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	

Additional Information			
Height	Weight	Does individual have a feeding tube? ☐ **Yes** ☐ **No**	Is individual on a ventilator? ☐ **Yes** ☐ **No**
Allergies			
Other Medical Information			

Part 2. Relationships with Family and Significant Others

Relationships – Describe current and past relationships, potential for sustaining family relationships and significant prior relationships.	
A.	If the child has been living out of the family's home, what has been the family's pattern of interaction with their child (e.g., number of facility visits, home visits, outings, letters, phone calls)? Has the family participated in service planning with the facility within the past year and been available to the facility when they were needed for medical decisions, etc.?
B.	Identify the people in the child's life, including caregivers, service providers, or others, with whom he/she has (or has had) significant relationship of affection and attachment. Describe the nature, duration, and continuity of each relationship.

Part 3. History Prior to Placement

A.	Continuity of services and service needs when living with birth family – consider the following: What were the family circumstances that prompted the family to seek a living situation for their child outside of the family home?
	What kind of help/supports did the family receive in caring for their child at home and who provided the help? What worked for the family and what did not work?
	Check all applicable reasons that led to the child's initial placement in a nursing facility: ☐ No supports ☐ Medical needs too high ☐ Inadequate supports ☐ Single parent ☐ Child is too big for parent to care for ☐ Behavioral issues ☐ Parents divorced/divorcing ☐ Facility can provide for medical needs ☐ Other:

B. Previous place settings. List placement settings in order (starting with the most recent); include times living at home or in foster care.

Name of Placement Setting	When and How Long	Type of Residence	Why Did the Child Leave This Setting?

Section 2. Goals for the Future

Part 1. Providing Information on Options

A. Family-Based Options

Goal	Description	Must choose one permanency goal Indicate by marking ☒
Goal 1	Bringing the child home with access to needed services	☐
Goal 2	Living with an alternate family with access to needed services	☐

Does the family support one of the family-based options (Goal 1 or 2)? ☐ **Yes** ☐ **No**

Comments:

Does the family understand it will retain parental rights when choosing any family-based option? ☐ **Yes** ☐ **No**

Summarize the discussion with the family/LAR and/or individual, including:

- The community living options information provided to the family/LAR and/or individual;
- The community living options that were visited by the family/LAR and/or individual and those in which there is interest in visiting; and
- Any issues, concerns, and questions identified by the family/LAR and/or individual.

Part 2. Supports Needed to Accomplish Goal

What will the child need to live at home or in another family-based setting?	Provide Details	Is this support needed in order for the child to live in a family?
Architectural Modifications		☐ **Yes**
Behavioral Intervention		☐ **Yes**
Child Care		☐ **Yes**
Crisis Intervention		☐ **Yes**
Durable Medical Equipment		☐ **Yes**
Family-Based Alternative		☐ **Yes**
In-Home Health Services		☐ **Yes**
MH Services, Counseling		☐ **Yes**
Nighttime Supervision		☐ **Yes**
Ongoing Medical Services		☐ **Yes**
Personal Assistance: Activities of Daily Living		☐ **Yes**
Respite: In Home		☐ **Yes**
Respite: Out of Home		☐ **Yes**
Special Equipment (include Adaptive Aids)		☐ **Yes**
Specialized Therapies		☐ **Yes**
Specialized Transportation		☐ **Yes**
Other Training for the Caregiver		☐ **Yes**
Transportation		☐ **Yes**
Volunteer Advocate		☐ **Yes**

Is this individual currently in the process of enrolling in any Medicaid waiver program (i.e. HCS waiver) or is eligible for "money follows the person" funding to leave a nursing facility (i.e. CLASS, MDCP)? ..... If yes, indicate which one:	☐ **Yes** ☐ **No**
Is this individual currently enrolled in any Medicaid waiver program (i.e. HCS waiver, CLASS, CBA, etc.)? ..... If yes, indicate which one:	☐ **Yes** ☐ **No**

Section 3. Action Plans

Concurrent Plans	**Activities**	**Action Plans**		
		Facility staff, LA staff, Relocation Specialist, Caseworker	**Family**	**Permanency Planner**
A. While remaining in the facility	Facilitate family involvement			
	Help child stay connected with family between visits			
B. When family agrees with the permanency goal #1 – increase possibility of child returning to live with birth family	When funding source is available for needed supports			
	While on waiting list			
C. When family agrees with permanency goal #2 – increase possibility of child living with another family	When funding source is available for needed supports			
	While on waiting list			
D. When the family is not in agreement with either permanency goal	Increase comfort with permanency goal			

Section 4. Participants

Name of Individuals Who Contributed to the Information Included in this Instrument	**Title or Relationship to Child**	**Indicate Method of Participation *(Mark with the date the participation occurred.)***				
		Face-to-Face: In a Planning Meeting	**Face-to-Face: In a Situation Other than Planning Meeting**	**By Telephone**	**Letter**	**Other Communication**
	Parent/guardian					
	Parent/guardian					
	Permanency Planner					

Parent/Guardian Information

Parent/Guardian Name	Driver's License No.	Home Area Code and Telephone No.	
Parent/Guardian Address (Street, Apt. No.)	City	State	ZIP Code
Parent/Guardian Place of Employment		Work Area Code and Telephone No.	
Address (Street, Apt. No.)	City	State	ZIP Code

Parent/Guardian Name	Driver's License No.	Home Area Code and Telephone No.	
Parent/Guardian Address (Street, Apt. No.)	City	State	ZIP Code
Parent/Guardian Place of Employment		Work Area Code and Telephone No.	
Address (Street, Apt. No.)	City	State	ZIP Code

Relative/Other Contact Name	Driver's License No.	Home Area Code and Telephone No.	
Relative/Other Contact Address (Street, Apt. No.)	City	State	ZIP Code
Parent/Guardian Place of Employment		Work Area Code and Telephone No.	
Address (Street, Apt. No.)	City	State	ZIP Code

☐ I agree to notify the local authority and the provider if any of the above information changes.

☐ I understand that my child's placement is considered temporary and that I will be contacted to participate in permanency planning activities every 6 months and service planning at least once a year.

☐ I agree to make reasonable efforts to participate in my child's life and in planning activities for my child.

Signature – Parent/Guardian _____ Date _____

Signature – Parent/Guardian _____ Date _____

Signatures required for initial permanency plans.
Parent/guardian must verify accuracy of information at permanency planning reviews.